

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**62-035786**

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 297 Primary Registration District No. 6022 Registrar's No. 108

VS 300  
Rev. 4/59

10890

20891

3

4 0

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9355X

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1286-0

132-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Ray</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Richmond Twp</u>		c. CITY OR TOWN <u>Richmond</u>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Elm Park Rest Home</u>		d. STREET ADDRESS (If outside, give location) <u>620 North Main</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Franklin Thomson</u>		4. DATE OF DEATH Month Day Year <u>Sept. 20 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>July, 20-1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Mail Carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carrying Mail</u>	
13a. FATHER'S NAME <u>John A. Thomson</u>		13b. MOTHER'S MAIDEN NAME <u>Julia Ann Stockard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral ischemia</u>		14. NAME OF HUSBAND OR WIFE <u>Betty Ann Moss</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>1960</u> to <u>present</u> and last saw her alive on <u>9-17-62</u>		22. SIGNATURE (Degree or title) <u>[Signature]</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9-22-1962</u>	
24. FUNERAL DIRECTOR <u>Jarman Funeral Home, Lawson, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-28-1962</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		27. LOCATION (City, town, or county) <u>9 Miles east of Lawson Missouri</u>	

(Licensed Embalmer's Statement on Reverse Side)

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Ralph Van Lindingham*

Licensed Embalmer No. 4909

*Deer Springs, Mo*  
P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.